IN THE

Supreme Court of the United States

October Term, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,
Appellants

vs.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA
Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Brief for Appellants

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CITATION TO OPINIONS BELOW

The September 16, 1977 opinion issued by the three-judge court is not officially reported. The opinion and order were filed in the United States District Court for the Eastern District of Pennsylvania at Civil Action No. 74-2440.

The opinions of September 4, 1975 are reported at 401 F. Supp. 554 (1975), judgment vacated and remanded 428 U.S. 901 (1976).

All opinions are set forth in their entirety in the Appendix.

JURISDICTION

Title 28 U.S.C. §12353 confers jurisdiction on this Honorable Court to review by direct appeal an order restraining state officials from enforcing a state statute.

Upon consideration on remand by this Court, the district court on September 16, 1977 filed a memorandum opinion and issued an order declaring §5(a) of the Abortion Control Act unconstitutional and permanently enjoined appellants from enforcement of that provision. Appellants filed a Notice of Appeal to this Court on October 12, 1977.

CONSTITUTIONAL PROVISIONS INVOLVED

Fifth Amendment to the Constitution of the United States:

> "No person be held to answer to a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in

jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation."

Ninth Amendment to the Constitution of the United States:

"The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people."

Tenth Amendment to the Constitution of the United States:

"The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

Fourteenth Amendment to the Constitution of the United States, in pertinent part:

"Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

STATUTORY PROVISIONS INVOLVED

The pertinent portions of the Pennsylvania Abortion Control Act, P.L. 209 of 1974, 35 Pa. Stat. Ann. §6601, et seq., 4 Pa. Leg. Serv. 74, 625, are set forth below:

Section 5. Protection of life of fetus.

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

• • •

(d) Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section, or who violates subsection (b) of this section, shall be subject to such civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted.

1974, Sept. 10, P.L. 639, No. 209, §5, effective in 30 days.

QUESTIONS PRESENTED

I. May the Pennsylvania legislature constitutionally mandate a standard of care for the protection of viable unborn life when the abortion procedure is performed after viability?

II. Does the terminology "may be viable", which requires utilization of the standard of care, reflect the semantic difficulty of translating medical statistics into probabilities of survival in defining the achievement of viability and thus does not describe a time period prior to viability?

III. Does not the judiciary, absent a constitutional violation, lack the power to qualify the compelling state interest in viable fetal life where the mother's life or health is not at stake?

STATEMENT OF THE CASE

A. Procedural History

The Pennsylvania Abortion Control Act (Senate Bill 1318; Act 209 of 1974) was passed into law on September 10, 1974, to be effective within thirty (30) days of passage.

Appellees filed the class action complaint on September 20, 1974. The plaintiffs were Planned Parenthood of Southeastern Pennsylvania, a corporation involved in abortion referrals, and John Franklin, M.D., a physician who was designated as a representative of an alleged class composed of all Pennsylvania physicians who perform abortions. Dr. Franklin sought to assert the rights of the physicians as well as those of the physicians' female patients. On September 28, 1974, the court set the hearing on the motion for a preliminary injunction for October 9, 1974. On October 4, 1974, an amended complaint was filed and, in essence, added Concern for Health Options: Information, Care and Education, Inc. (CHOICE), and Clergy Consultation Service of Northeastern Pennsylvania as plaintiffs in this action. Both of these organizations operate abortion referral services. On October 9, 1974, after oral argument on the motion for preliminary injunction, the Obstetrical Society of Philadelphia, successfully moved to intervene as a plaintiff. By order dated September 4, 1975, the court granted Appellants' motion to dismiss Planned Parenthood, CHOICE and Clergy Consultation Service as plaintiffs in this action.[1]

The original complaint named the District Attorney of Philadelphia and the Secretary of Welfare as defendants.[2]

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[1]Consequently, Planned Parenthood, CHOICE and Clergy Consultation Service have been eliminated from the caption of this case and are not identified as appellees before Your Honorable Court.

[2]At the time this action was commenced, Helene Wohlgemuth was the Secretary of Welfare of Pennsylvania. During the course of this litigation, she was replaced in that position by Frank S. Beal, who is designated as one of the appellants herein.

The Attorney General of Pennsylvania and the Commonwealth of Pennsylvania intervened as defendants in this action.

At the hearing on the motion for preliminary injunction, in spite of an Answer denying the plaintiffs' allegations, plaintiffs offered no testimony, affidavits or evidence of any nature in support of their contentions. Nonetheless, the three-judge court issued a preliminary injunction on October 10, 1974, which restrained the appellants from enforcing crucial provisions of the Act.

The trial of this case commenced on January 13, 1975 and continued for five full days, concluding on January 17, 1975. During the trial the court heard actual testimony from six witnesses for appellees and eleven witnesses for appellants. Additionally, the court received testimony by way of depositions from two witnesses and affidavits from an additional six witnesses. The majority of the witnesses called in this action were medical specialists, physicians, psychiatrists or social workers and, consequently elaborate expert testimony was elicited on all aspects of abortion procedures.

Judgment was rendered in this case on September 4, 1975. The court declared the Act to be severable and upheld the constitutionality of Section 2's definition of "informed consent", Section 3(a), Section 5(c), Section 6(a), Section 6(c) and Section 8. The lower court declared Section 2's definition of "viable", Section 3(b) (ii), Section 5(a), Section 6(b), Section 6(f) and Section 7 unconstitutional. In its Order, the Court ruled that a portion of 6(d) was constitutional and another portion of that section was unconstitutional. The full text of the Opinions and Order are set forth in the Appendix beginning at 154a.

Appellants in the instant appeal have previously appealed to this Honorable Court in a case styled ***Beal, Secretary of Welfare v. John Franklin, M.D., et al.***, filed at

No. 75-709 October Term, 1975. The appellees herein also appealed those portions of the lower court's judgment adverse to them in a case styled *Franklin, et al. v. Fitzpatrick District Attorney of Philadelphia, et al.*, filed at No. 75-772. Appellees' appeal was disposed of by this Court affirming the judgment in *Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

On July 6, 1976, appellants' prior appeal was disposed of by Order vacating the lower court's judgment and remanding the case:

> "The judgment is vacated and the case is remanded to the United States District Court for the Eastern District of Pennsylvania for further consideration in light of Planned Parenthood of Central Missouri v. Danforth, ___ U.S. ___ (1976); Singleton v. Wulff, ___ U.S. ___ (1976), and Virginia State Board of Pharmacy v. Virginia Citizen's Consumer Council, 425 U.S. ___ 1976. Mr. Justice Stewart and Mr. Justice White would note probable jurisdiction and set the case for oral argument."

After remand to the lower court, the parties entered into a Stipulation which disposed of all of the remanded issues with the exception of §5(a), the subject of this appeal, and §7 of the Act relating to governmental subsidy of abortions.[3]

The lower court found that §5(a) was violative of the United States Constitution in the Memorandum Opinion dated September 16, 1977, a copy of which is contained in the Appendix beginning at 254a.

B. Evidence at Trial Relating to Section 5(a)

In the court below, plaintiffs elicited testimony from two physicians who challenged the definition of "viability" as unclear and imprecise.

Dr. Louis Gerstley testified for plaintiffs that there are "too many variable factors that occur" in order to determine

[3]Appellees have not appealed the lower court's determination that Section 7 was constitutional.

if a particular fetus is viable (6a). Despite diagnostic tests, his judgment could be made "only roughly" (6a). In terms of gestational age, he would place viability at approximately 24 to 26 weeks' gestation at the earliest. He did not feel that the fetus born prior to 24 weeks gestation has any "reasonable chance of survival" which he defined as "at least on terms of five percent, and even by any extrapolation you may wish to use, certainly at least two to three percent" (8a). He would also allow for a margin of error of at least two weeks (R.31).

Dr. Gerstley further testified that for second-trimester abortions he preferred to use the method of saline amnio-infusion. He prefers the saline method over prostaglandins because "they have side effects ... that frequently are uncomfortable" (11a), might require repeated doses and "*there is the much greater incidence of the possibility of the fetus being born alive after a prostaglandin infusion, than there is with a saline*" (11a-12a).

It was Dr. Gerstley's further opinion that in order to deliver a 26-week viable fetus alive, he would use high dosages of oxytocin or perform a hysterotomy. He felt that a hysterotomy was "more immediate and less expensive and time-consuming" (13a) but felt that for the delivery of future children this mother would have to undergo a Caesarian section. He stated that his belief was "open to differing medical opinion" (13a).

On cross-examination, Dr. Gerstley stated that he wished the statute would define viability not only with gestational age but also with patient history and uterine size (17a). It was also his belief that *all* abortions, elective or not, have medical indications (R. 49). In questioning relating to a 1972 survey of the plaintiff Obstetrical Society of Philadelphia, Dr. Gerstley stated that the majority felt that abortions should not be performed beyond sixteen weeks gestation (R. 53). He later revealed, on redirect, that the overwhelming majority surveyed felt that *physicians or*

hospitals (as opposed to state legislature or federal government) *should regulate abortion practice* (19a).

Plaintiff Dr. John Franklin testified that at a diagnosed 24 weeks gestational age, a fetus had a 5% probability of survival but at 28 weeks had a "real probability" (20a). On cross-examination he admitted that "there is some increasing degree of viability or survival of the fetus" between 24-28 weeks (26a). He stated that he has found from his readings that physicians disagree with his views, but admitted on cross that these differences related to philosophical arguments over when life begins (25a). He felt that "as technical skills improve" the gestational age/survival ratio will improve (21a).

It was Dr. Franklin's opinion that in a mid-trimester abortion the fetus had the best opportunity for survival by use of the hysterotomy method. Complications would be limited to those attending any surgical procedure (23a). On cross, he testified that the saline procedure is fatal to the fetus but that the prostaglandin infusion stimulates uterine contraction rather than killing the fetus (28a). In terms of complications to the mother, he felt that the risk of health to the mother in a hysterotomy procedure was not great (29a) and was less life-threatening to the mother than a saline infusion (30a).

On cross-examination Dr. Franklin stated that the viability of each fetus must be determined on an individual basis. He testified that physicians "*cannot judge prior to delivery* except to arrive at some probability that I believe the mother is 26 or 28 or 24 weeks" (24a).

Dr. Franklin was concerned that neonatologists (specifically Dr. Mary Louise Soengten) would want him to use an abortion method which would save "the lives of very young immature babies". It was his emphatic opinion that if his woman patient wanted an abortion, he should be permitted to perform to it without being required "*by the*

State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus" (33a). The "vast sum of money" ... "certainly enter" into his decision (33a). However, where the child was wanted by the mother, he has taken steps toward maintaining the spontaneously aborted child's life (34a).

Dr. Hope Punnett, on behalf of the plaintiffs, directed her testimony to genetic counseling and the time frame within which testing can be completed. Dr. Punnett discussed two specific types of disorders which are identifiable prenatally: auto-somal disease (*e.g.*, Tay-Sachs) and chromosomal defect (*e.g.*, Down's Syndrome). The diagnostic procedure involves the removal of amniotic fluid from the sac by embryotic tap, growth of cells from the fluid, and testing of the cells for particular substances (50a).

Dr. Punnett testified that due to small uterine size, it is not feasible to obtain the amniotic fluid if the fetus is under 16 weeks' gestational age. If the cells from the fluid grow, the tests can be completed from two to six weeks (53a). The gestational age of the fetus approximated 18 to 20 weeks (53a). According to Dr. Punnett, there is the possibility that the cells will not grow and a second embryotic tap must be performed. Dr. Punnett expressed concern that hospitals might cut off abortions at twenty weeks' gestation when a small number of families might not yet have testing results completed. Of her own knowledge, she knew of only one case where testing exceeded twenty weeks gestation (58a).

On cross, Dr. Punnett explained that if both parents are Tay-Sachs carriers, there is a 25% chance that the child has Tay-Sachs. When asked about medicine's progress in treating genetic defects, Dr. Punnett expressed her personal viewpoint concerning the physician's role in advising the woman to carry the child to term: " ... if the child is salvageable ... (t)his is a family decision. It is not my decision to impose on the family" (63a).

In their case-in-chief, defendants presented Dr. Fred Mecklenburg who testified as to abortion methods and complications. With respect to saline infusion, he stated that the saline solution "almost invariably kills the baby" (36a) and has serious side effects for the mother: "The clotting mechanism of the person in a saline abortion is influenced 100 percent of the time" (38a). Some cases are severe and deaths have occurred. If the saline solution enters the mother's blood stream or into the abdominal wall, a hazardous condition occurs and lives have been lost (38a). In addition, risk of injury to the cervix, perforation of the bowel and the threat of infection exist (42a).

With respect to prostaglandin infusion, Dr. Mecklenburg described two methods of instillation. If given intravenously, there are high incidents of severe headaches, diarrhea and nausea. If administered into the uterus, the side effects are less severe. With the use of this method, the baby survives (37a).

Dr. Mecklenburg testified that during the hysterotomy, the baby is removed from the placenta through an incision in the mother's abdominal wall. The risks to the mother would be the same risks in any operative procedure utilizing anesthesia and incision of tissue (39a, 43a).

In the procedure known as the D & E, the cervix is forcibly opened, a powerful suction several times the atmosphere of the earth is introduced, and the fetus is reduced "to the consistency of crankcase oil" (35a). A long knife (curette) is generally then introduced to scrape out any remaining tissue (35a) in order to prevent hemorrhage (36a). Dr. Mecklenburg testified that this procedure is generally utilized for abortions prior to 7 weeks. Subsequent to 7 weeks, the fetal skeletal system begins to form and it is hazardous to extract bone from the mother's womb (39a-40a).

With respect to determining viability, on cross Dr. Mecklenburg stated that it is very difficult to determine in a

woman who is pregnant in the 20th to 28th week period. However, by examination of the patient, a physician could ascertain gestational age within 3 to 4 weeks (44a). Dr. Mecklenburg agreed with the statute's definition of viability, that it is current and takes into account medical progress (44a).

Dr. Thomas W. Hilgers, testifying on behalf of the defendants, described the short-term and long-term complications of the various abortion methods. With respect to saline infusion, Dr. Hilgers described infection, hemorrhaging and a high incidence of retained placental tissue which requires removal by curette (69a). In addition, a reaction that affects the blood's ability to clot occurs. In rare occasions major bleeding will occur, statistically low but significant because maternal deaths have occurred (71a).

With respect to prostaglandin infusion abortions, Dr. Hilgers testified that although research in prostaglandin use is in its infancy, he felt that it was as comparably safe as a saline infusion from a morbidity/mortality point of view (72a). He recommended the prostaglandin abortion as the best procedure for live delivery of a 4-1/2 to 5 month fetus weighing 400 grams (81a).

Dr. Hilgers described the hysterotomy procedure as having "the same problem as any major abdominal operation" (73a). He characterized the hysterotomy as having the highest mortality rate of all abortion procedures and cited infection and hemorrhage as primary complications. He felt that accepted medical practice would require all future children to be delivered by C-section (73a).

Dr. Hilgers described the immediate complications of the D & E method of abortion as infection, hemorrhage and perforation of the uterus or bowel (resulting in overwhelming abscesses, peritonitis, or anemia (64a-65a; 67a-68a). It was his opinion that this method carried the greatest risk of long-term complications: prematurity in subsequent preg-

nancies, longer labor and excessive bleeding in future pregnancies, greater incidence of ectopic pregnancies and infertility.

On cross-examination, Dr. Hilgers testified that although viability can never be determined accurately before the child's birth, some reasonable judgment can be made based upon patient history, size of infant, uterine size, gestational age, medical facilities in the community, and racial differences (77a-79a, 81a).

With respect to premature infants and the significance of mental and motor retardation, Dr. Hilgers cited recent advances leading to the prevention or decreased intensity of these difficulties (75a).

Dr. Arturo Hervada, board-certified pediatrician and Associate Chairman of Pediatrics at Jefferson Medical Center in Philadelphia, testified on behalf of the Commonwealth. Dr. Hervada stated statistical applications in medicine are constantly changing and abhorred a computerization in the practice of medicine (R. 583). However, with respect to viability and its determination, Dr. Hervada found no difficulty in visualizing any groups of competent physicians coming to a consensus regarding viability on any particular patient (R. 588, 595-596).

Dr. William Keenan, a board-certified pediatrician with a sub-specialty in neonatology, traced the development of human gestational development from conception to viability to birth. At the approximate gestational age of 26 weeks, Dr. Keenan identified the ability of the fetus for gas exchange and ventilation without dependence upon the placenta. At this particular stage of development, Dr. Keenan estimated a survival rate of 50% in premature infants (92a). It was his expert medical opinion that viability exists where a 10% anticipated rate of survival occurs (92a-93a). While Dr. Keenan described the determination of viability as a difficult one, he felt that competent medical practitioners

would agree substantially in their opinions concerning a particular patient (R. 552-553, 556, 572). On cross-examination, Dr. Keenan stated that prostaglandin infusion and C-section were both utilized for late abortions, but the decision to use one method over the other was clearly outside his medical expertise (R. 575-576).

The defendants additionally offered the affidavits of four obstetricians from the Philadelphia area to the effect that the statute's definition of viability "comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area, understand this term". In addition, these physicians averred under oath that they frequently are called upon to determine the viability of a fetus: a "relatively uncomplicated procedure" based upon patient history, clinical examination and medical judgment (Defendants' Exhibits W, X, Y and Z, R. 602, 145a-150a).

SUMMARY OF ARGUMENT

In full compliance with *Roe v. Wade*, 410 U.S. 113 (1973), *Doe v. Bolton*, 410 U.S. 179 (1973), and *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the Pennsylvania legislature in §5(a) of the Abortion Control Act mandated the use of a standard of care for post-viability abortions. This standard reflects the Commonwealth's compelling interest in viable unborn life and does not unconstitutionally invade the privacy of the abortion decision nor have a chilling effect thereon. In circumstances limited by §6(b) (to preserve the life or health of the mother), physicians may perform post-viability abortions.

Therefore, where the mother is entitled to a termination of her pregnancy in which the fetus has attained viability, the mother is not additionally entitled to have the viable fetus destroyed.

Physicians desiring to perform second-trimester abortions are *not* required to make a further judgment *other* than

viability. The medical determination of when a particular fetus achieves viability depends upon many factors, including statistical probabilities of survival based upon age and weight. The terminology used in §5(a) simply incorporates the flexibility required for sound medical practice.

The well recognized standards set forth in §5(a) are sufficiently definite. Physicians governed by §5(a) are clearly notified of the steps which must be taken for a post-viability abortion. Physicians are required simply to utilize the same degree of skill encountered in any other area of medical practice.

The state legislature is the proper arena for determining when and in what manner the state's compelling interest in protecting viable fetal life is manifested. Absent a violation of constitutional proportions, the judiciary has no power to set forth or strike down grounds for post-viability abortion. This principle of law remains constitutionally stable regardless of the genetic disease or chromosomal defect the viable fetus suffers.

ARGUMENT

INTRODUCTION

The facial question before the Court is whether the lower court erred in declaring unconstitutional the mandate of Section 5(a) which requires the physician who performs an abortion from viability onward (if permissible under Section 6(b)[4] to utilize the abortion technique best able to ensure the life of the fetus.

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[4]Section 6(b) proscribes abortions from viability onward in the following manner:

> Section 6. Control of Practice of Abortion
>
> (b) No abortion shall be performed within the Commonwealth of Pennsylvania during the state of a pregnancy subsequent to viability of the fetus except where necessary, in the judgment of a licensed physician, to preserve the life or health of the mother.

In the lower court, appellees successfully argued that the terminology utilized in §5(a) to describe a pre-condition to utilization of this standard of care was unclear and established an additional time period prior to viability during which abortions would be proscribed.

In addition, appellees set forth several challenges to §5(a) which the lower court did not rely upon in declaring this section unconstitutional: 1) that the effect of requiring protection for the unborn would have a chilling effect on the alleged right to choose an abortion and 2) that the pregnant woman seeking genetic counseling might not have the results in time for an abortion when her purpose is to destroy the fetus. Appellees have placed these issues before your Honorable Court in the Motion to Dismiss or Affirm.

The Commonwealth urges this Court to confine its inquiry to a review of the question of error by the lower court based upon the stated rationale. However, because appellees are raising these issues, the Commonwealth will extend the scope of this brief to a discussion of these additional arguments not only as a protective measure but chiefly to present the entire range of the ramifications of §5(a) to this Court for its edification. Also set forth is supporting medical and statistical data relevant to the inquiry.

It should be noted that the lower court struck down §5(a) in its entirety rather than merely the offending clause. Consequently, at present there is no legislatively-mandated protection for the unborn who is the target of a §6(b) abortion.

I. THE LOWER COURT ERRED IN DECLARING UNCONSTITUTIONAL THE MANDATE OF SECTION 5(a) WHICH REQUIRES THE PHYSICIAN WHO PERFORMS AN ABORTION FROM VIABILITY ONWARD TO PROTECT THE LIFE OF A FETUS.

a. The legislature has the power to regulate abortion methods for fetal protection in post-viability abortions where the abortion is performed to save the life or health of the mother.

This Court has recognized in *Roe v. Wade, supra, Doe v. Bolton, supra,* and *Planned Parenthood v. Danforth, supra,* that from viability onward the state's interest in the protection of prenatal life outweighs a woman's right to an abortion. Mr. Justice Blackmun, writing for the Majority in *Danforth*, emphatically stated that the Court in *Roe* rejected the premise "the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses". (428 U.S. at 60). Consequently this right of privacy "must be considered against important state interests" (428 U.S. at 61) in regulating the practice of abortion, including the state's compelling interest in protecting life subsequent to viability. The Commonwealth of Pennsylvania has recognized its compelling interest through the enactment of §5(a).

The ostensible question before this Court is whether the language in this section represents a constitutional implementation of this recognized and accepted state interest in protecting viable fetal life where the abortion itself is legislatively permitted under §6(b) in order to save the life or health of the mother.

It must be stressed initially that §5(a) does not in any way inhibit the performance of abortion, *i.e.*, the termination of pregnancy. Section 5(a) expressly provides that the protection of the life of the fetus must be subordinated to the needs of the mother if necessary to preserve the life or health of the mother.

Appellees argued below, however, that in effect, an abortion is not merely the termination of pregnancy. Since the mother does not want to carry the child to term, the appellee-physicians do not want to take any steps to preserve the life. At trial, appellee Dr. Franklin testified in this regard:

> Mr. Mansmann:
>
> Q. It is not your opinion that you as a physician ... should attempt to save the life of the child who can be saved?
>
> Dr. Franklin:
>
> A. I didn't say that. My opinion is that if the woman is seeking a termination of a pregnancy that I should be permitted to terminate her pregnancy. I should not be required by the State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus.

Dr. Franklin's views regarding the extent the law should concern itself with the preservation of life were frankly expressed in his deposition introduced at trial wherein he stated:

> Mr. Morris:
>
> Q. And do you agree that at some point — and this is probably your own philosophical reasoning — at some point there is an interest in the preservation of that fetus?
>
> A. Not necessarily. I have thought a lot about this question and I believe that life is extended to a fetus or a baby capable of living, if the baby is neglected in some way, that does not live, so that *one of the*

> *pre-requisites for life is that someone wants you to live*. It may be that they want you to live enough to start an i.v. or to put you on a breathing machine or ventilator but it simply may be that you can be brought into a household where you are fed and sheltered and clothed but the message is you are not wanted, and I believe there is good documentation of absence of growth in children for emotional reasons, namely, societal rejection, and there is a famous paper from the 30's of a nursery where babies were attempted to be raised in total asepsis, no bacteria at all, and these babies died because they were not handled, not talked to, in fact, neglected. *So my own philosophical definition of life necessitates other human beings who want you to live*. (85a-86a) (Emphasis added).

Appellees are presenting an issue of first impression to your Honorable Court with respect to the *per se* applicability of the standard of care to post-viability abortions.[5] An argument closely on-point was set forth in *Wynn v. Scott*, No. 75 C-3975 (E.D. N.D. Ill. filed April 12, 1978). In writing the Opinion of the three-judge statutory court, District Judge Marshall upheld an almost identically-worded statute:

> They contend that §6(1), though limited to abortions after the fetus is viable, improperly strikes the balance in favor of the fetus and against the woman. In essence, plaintiffs' position is that abortions after viability are permitted only when the woman's life or health is in jeopardy. In that situation, the physicians' primary concern should be in the health of the woman. Section 6(1) distracts the physician from caring for her needs. In fact, it requires the physician to sacrifice the woman for the unborn fetus, when the needs of the two conflict.

[5]In *Danforth* this Court was asked to strike a similar provision of the Missouri Act chiefly on the grounds it presumably applied to *all* abortions, regardless of the viability standard and not because of a "chilling effect" upon the constitutionally protected right of the woman.

> We disagree with this interpretation of §6(1). It does not require that the physician increase the risk to the woman in order to save the fetus. If, however, there are instances where a physician has a choice of procedures, both of equal risk to the woman, the physician must choose the procedure which is least likely to kill the fetus. This choice would not interfere with the woman's right to terminate her pregnancy. *It never could be argued that she has a constitutionally protected right to kill the fetus. She does not*. (Slip op. at 48-49). (Emphasis added.)

By way of footnote, Judge Marshall maintains that plaintiffs have agreed by implication that "when there is no conflict between the needs of the woman and the needs of the fetus, it is not improper for the state to insist that the physician be responsible for caring for the fetus as well as for the woman. Certainly the physician has the duty to care for both at a normal delivery" (Slip op. at 48 n.12).

Dr. Sissela Bok, a lecturer at Harvard Medical School, recently addressed this practical problem with the following conclusion:

> The termination of early pregnancy carries with it, at present, fetal failure to survive. But in later pregnancy, where abortion and death of the fetus do not necessarily go together, it is a fallacy to believe that a right to the first also implies a right to the second. I can maintain, then, without contradiction, that abortion is justified, but that if a live birth would result, it must be protected.
>
> Bok, The Unwanted Child: Caring for the Fetus Born Alive After An Abortion, Hastings Center Report, p. 12 (October 1976).

Dr. Bernard N. Nathanson, Chief of Obstetrics at St. Luke's Hospital, New York City, balances the woman's and the fetus' rights:

> The dimensions of this dilemma were exemplified by the *Edelin* case, which was a profound misunderstand-

> ing. Dr. Edelin regrettably labored under the same misapprehension that a great many obstetricians and pro-abortion advocates have labored under: that abortion necessarily implies the death of the products of conception. *It does not now and it never did. Abortion merely intends to remove the products of conception from the unwilling host.* And if one views abortion in that way — namely, that the woman's rights as the unwilling host are respected and that the products of conception are removed — then the fetus's rights . . . are also respected in that it is removed and cared for in the best manner possible.
>
> Nathanson, The Unwanted Child: Caring for the Fetus Born Alive After An Abortion, Hastings Center Report, p. 12 (October 1976). (Emphasis added).

Therefore, §5(a) does not unconstitutionally interfere with a mother's "right" to an abortion. The section merely implements the state's compelling interest in the protection of the unborn by putting the physician on notice to consider fetal viability in selecting the abortion *method* in post-viability abortions.

b. The statutory mandate of Section 5(a) reflects the existence and availability of abortion methods capable of terminating pregnancy and producing a live birth.

In the court below appellees attacked §5(a) on the additional ground that the abortion method best calculated to preserve fetal life after viability is not ever the method best for the woman. While appellees offered no testimony in this regard, appellants' witnesses described several methods capable of terminating the pregnancy and producing a live birth and delineated all of the potential complications. This testimony is set forth in detail in the Statement of the Case: B. Evidence at Trial Relating to Section 5(a), *supra*. Appellants respectfully submit that this standard of care is grounded in contemporary medical practice and is adaptable to the constant advancement and evaluation of medical

knowledge and technology. *Wynn v. Scott, supra*, slip op. at 50.

A review of the contemporary medical literature clearly reflects the existence of several alternative abortion techniques adaptable to mid-trimester pregnancy, with significantly varying risks and potential complications to the life and health of both mother and fetus. As appellants will demonstrate, the state of the art is such that all other things being equal, a competent physician can easily determine whether in any given case a procedure exists to safely abort a woman in a manner most conducive to the continuation of viable fetal life.

If abortion is selected during the mid-trimester, all medical authorities agree that the easiest and safest abortion techniques utilized in early pregnancies, with the fewest risks to life and health of the mother, *i.e.*, menstrual extraction, vacuum aspiration, and dilation and curettage) are no longer feasible abortifacients. *However, there are several methods available, all of which protect the life and health of the mother, but with dramatically different consequences to the possible survival of viable fetal life.*[6] Appellants will briefly review the available techniques, in descending order of their likelihood of aborting a live fetus.

HYSTEROTOMY

The hysterotomy is basically a caesarian section operative procedure and a recognized abortion alternative to live birth with the highest incidence of fetal survival of any of the abortifacients. Medical experience has shown that

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[6]Initially, it should be recognized that maternal life is best protected at least from the 16th week of gestation onward by carrying the fetus to term. See, National Center for Health Statistics, DHEW, Vital Statistics of the United States: Vol. 11, Mortality, 1972-1975, Standardized to Population of Women Obtaining Abortions in the United States. Table Six therein graphically illustrates the geometric raise in risk to maternal life in any abortion technique at the sixteenth week.

mid-trimester hysterotomy is characterized by a relatively high rate of fetal survival in comparison to fetuses aborted with prostaglandins and hypertonic saline infusion. William E. Brenner, M.D., University of North Carolina, Chapel Hill, N.C., OB-GYN Collected Letters, Series XV, p. 165, (November 1, 1974). It would appear, subject to continuing medical research and expanding knowledge in this area, that hysterotomy is the preferred procedure to induce a live birth.

PROSTAGLANDINS

A relatively recent innovation in abortifacients has been the use of prostaglandins. The result is achieved by intraamniotic injections of prostaglandins by syringe into the uterus, which stimulates uterine contractibility and induces labor, resulting in expulsion of the second trimester fetus through the cervix within thirty hours of injection. While there is some noted incidence of vomiting and diarrhea among women aborted by this method, it is generally conceded that prostaglandins are safe and effective for induction of abortion. Am. J. Obstet. & Gyn. 192:597 (1977), Studies Carried Out Under Steering Committee of the World Health Organization Task Force in Use of Prostaglandins for the Regulation of Fertility.

Prostaglandins appear preferable over saline injection due to decreased risk of cardiovascular failures, lack of coagulation effects, elimination of the risk of hyponatremia, and lack of tissue damage from inappropriate administration. Moreover, it is foreseeable that prostaglandin compounds will be developed that will have negligible side effects, with action restricted solely to the uterus. "Nursing Times", November 18, 1976, Nils Wiqvist, M.D., Stockholm, Sweden, Comments noted in OB-GYN Collected Letters, Series XV, p. 164-165 (November 1, 1974).

With reference to the physician's duty of care to the potentially viable fetus, it is accepted medically that the

incidence of a live born fetus is significantly greater on a statistical basis by use of the prostaglandin method over saline infusion injection. See also G. Stroh and A. R. Hinman, "Reported Live Births Following Induced Abortions: Two and One-Half Year's Experience in Upstate New York". Am. J. Obstet. & Gyn. 126:83 (1976).

SALINE AMNIOINFUSION

Also known as intraamniotic injection (IAI), this method of pregnancy termination involves the removal of amniotic fluid (amniocentesis) and instillation of a hypertonic 20% saline (sodium chloride) solution into the amniotic sac by a spinal needle inserted through the abdominal wall. The injected solution increases uterine activity such that expulsion of the fetus occurs usually between 17 and 35 hours after injection, usually resulting in the death of the fetus. Jaffin, Herbert, Thomas Kerenyi and E. C. Wood; Am. J. Obstet. & Gyn. 84:602 (1962).

The use of oxytocin by intravenous injection has been rated as a stimulant to a shorter injection-abortion interval. Schulman, Joseph D. and Niels H. Lauersen; The Lancet, 1:606 (1971). Also the use of other intraamniotic hypertonic agents, such as glucose and urea have been documented. Brosset, A., Obstet. Gynec. Scand. 37: 519 (1968); Greenhalf, J. O., Brit. Med. J. I:107, 1971.

Alternatives to saline injection are constantly being explored, due to reported complications; such as hypernatremia, renal failure, transplacental hemorrhage, pulmonary embolism, cardiovascular failure, endometritis, hypofibrinogenemia, necrosis, and severe vomiting. Howard Berk, M.D., "Complications of Intrauterine Instillation of Saline for Abortion, Contemporary OB/GYN Vol. 2, No. 6, p. 11-13; Wagatsuma, J., "Intraamniotic Injection of Saline for Therapeutic Abortion", Am. J. Obstet. & Gyn. 93:747 (1965); David H. Sherman, M.D., "Salting out: Experience in 9,000 Cases", J. Repro. Med. Vol. 14, No. 6,

pp. 241-243 (June 1974); Stephen R. Lenkin, M.D. and Herman E. Kattlove, M.D., "Maternal Death Due to DIC after Saline Abortion", Obstet. & Gyn. Vol. 42, No. 2, pp. 233-235 (August 1973). As the last source indicates, death resulting from any of the above complications is not unknown.

DILATION AND EVACUATION

D & E involves surgical removal of the fetus, accomplished with cervical dilation by graduated dilators and the use of crushing forceps or sharp curettage. The physician must crush and dismember the fetus piece by piece in the uterus, and reconstruct it after removal to insure completeness of the abortion procedure. The technique is being employed even in 16th to 20th week of pregnancy. "MDs Shun 16th Week D & E as Reminder of Destroyed Fetus", Medical Tribune, p. 9, Wednesday January 25, 1978; Judith Bourne Rooks and Willard Cates, Jr., "Emotional Impact of D & E vs. Instillation", Family Planning Perspectives, Vol. 9, No. 6 (November, December 1977).

OTHER METHODS

The above procedures are not the only known abortion methods. Among the techniques which have been used are utilization of phospholipids, serotonin and monoamine oxidase inhibitor pastes, extra-amniotic solutions, bougie and metreurynters. Techniques Applicable to Mid-trimester Abortion, Obstetrical-Gynecological Survey, 1974. However, the techniques discussed previously are those commonly utilized.

Appellees recognize the existence of a dispute among medical authorities on the relative safety and merits of the various procedures. Prostaglandins have proponents and the medical community also numbers advocates of D & E, hysterotomy, the use of oxytocins, and to a lesser degree, saline infusion.

The appellants submit that the only legally relevant considerations are that alternatives exist among abortifacients, and that the physician, mindful of the state's interest in protecting viable life, must make a competent and good faith medical judgment on the feasibility of protecting the fetus' chance of survival in a manner consistent with the life and health of the pregnant woman. The standard is one grounded in the present reality of abortion practice by use of hysterotomy and prostaglandins, and adaptable to the constantly expanding medical advances which the future may provide.

II. THE STATUTORY REQUIREMENT THAT A PHYSICIAN UTILIZE THE STANDARD OF CARE IF THERE IS SUFFICIENT REASON TO BELIEVE THAT THE FETUS MAY BE VIABLE IS A CONSTITUTIONALLY-PERMISSIBLE MANIFESTATION OF THE STATE'S COMPELLING INTEREST IN FETAL LIFE

a. The terminology "may be viable" correctly describes the statistical probability of fetal survival.

Section 2 of the Pennsylvania Act defines viability in the *precise* terms approved in *Roe* and clarified in *Danforth*.[7] Section 5(a), entitled "Protection of Life of Fetus", mandates, *inter alia*, protection of unborn life when in the experience, judgment and professional competence of the physician, there is sufficient reason to believe that the fetus may be viable.

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[7]Pertinent portions of Section 2 read as follows:

Definitions.—As used in this act:

• • •

"Viable" means the capability of a fetus to live outside the mother's womb albeit with artificial aid.

In the court below, appellees alleged that physicians were being required to make a *further* judgment beyond viability to a nebulous period denoted as the "may be viable" stage. Appellees argued that a gestational time period must be set so that physicians desiring to perform abortions would know with *absolute* certainty (not based upon their best medical judgment of the viability of a particular fetus but upon an inflexible time period) what was prohibited.

This Court in *Danforth* categorically and clearly rejected the notion that to be constitutionally valid a definition of "viability" must contain a reference to a gestational time period. The Court stated that it has recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability and that the flexibility of the term should be preserved.

The Commonwealth submits that the wording "may be viable" does not carve out an additional time period. It simply incorporates the flexibility necessary to place the protection of fetal life in a realistic context, and recognizes the inherent dilemma faced by a legislative body when articulating a cut-off point in fetal life after which that life is to be protected.

From a purely scientific point-of-view, it is clear that before birth no medical expert could guarantee 100% that a particular fetus, of any gestational age, will absolutely live outside the womb.[8] A physician can only predict, on the basis of statistical studies, that this fetus will be able to live after delivery.[9] In drafting terminology to accommodate this difficulty in hurdling the gap between medicine and law, the Pennsylvania legislature described this statistical problem in terms of "may be viable" language.

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[8]Appellee Franklin testified as to this inherent difficulty of prediction (24a), and appellants' witness Hilgers confirmed (77a).

[9]In this regard, the Commonwealth would draw the Court's attention to the expert medical testimony of appellants' witnesses Dr. William

(Continued)

In December of 1977, the American College of Obstetricians and Gynecologists strongly reaffirmed a statement of policy disseminated in December of 1975 with respect to ethical considerations in induced abortions. Clearly on point is the terminology which the College chose to use in describing the fetus:

Keenan and Dr. Arturo Hervada, both of whom stressed the fact that any determination of viability is based on many factors and involves an innate inexactitude.

Dr. Kennan, a board-certified pediatrician with a sub-specialty in neonatalogy, which deals with the care of an infant prior to delivery, exhaustively explained the current state of medical knowledge of human gestational development (R. 527-529). Dr. Keenan traced the progressive development of the human fetus from conception to the approximate gestational age of 26 weeks, at which point the fetus has developed the ability for gas exchange and ventilation without dependence upon the placenta. At this stage, he estimated a survival rate of 50% in premature infants (92a). It was his expert medical opinion that viability exists where a 10% anticipated rate of survival occurs (92a-93a). Appellee Franklin also stated that viability as understood by the medical profession occurs where the unborn child has a 10% chance of survival (R. 600).

Appellee Dr. Louis Gerstley testified that a "reasonable chance of survival is at least on terms of five percent, and even by any extrapolation you may wish to use, certainly at least two to three percent." (8a).

On a related point, Dr. Keenan explained that of babies born at 26 weeks gestation, only a small percentage have any mental or motor defects. But most importantly, fantastic progress is being made to correct and prevent these deficiencies. For a most recent update, see the fascinating article by Annabel Teberg, M.D., et al. entitled "Recent Improvement in Outcome for the Small Premature Infant" published in Clinical Pediatrics (Apr. 1977).

During the course of Dr. Keenan's practice he frequently found it necessary to make a determination of viability and in so doing utilized what he classified as the standard threefold test: menstrual history, external examination and his best medical judgment (93a-97a). He noted that even in a fully-equipped teaching hospital, viability cannot be ascertained with certainty in every case, due to variables such as sex and race, and possibilities that physical conditions of the woman, such as hypertension and diabetes, could affect fetal size (98a-100a). This would not be obviated by the use of amniotic fluid analysis (amniocentesis), sonar examination of crown-rump length or other advanced techniques which also contain sources for error (100a-101a).

> The College consequently recognizes a continuing obligation on the part of the physician towards the survival of *a possible viable fetus* where this can be discharged without additional hazard to the health of the mother.
> ACOG, Statement of Policy: "Further Ethical Considerations in Induced Abortions", p. 4 (December 1977). (Emphasis added.)

The College deliberately selected terminology which describes, as does the "may be viable" language of §5(a), the statistical probability of survival rather than the actuality of viability.

The Pennsylvania Legislature's use of the terms "may be viable", therefore, simply incorporates the acknowledged medical fact that a fetus is "viable" if it has that statistical "chance" of survival recognized by the medical community. This relative uncertainty but firm possibility of actual viability was recognized by this Court in *Danforth* when it stated:

> [I]t is not the proper function of the legislature or the Courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, ***and must be***, a matter for the judgment of the responsible attending physician. The definition of viability in Section 2(2)[10] hereby reflects this fact (428 U.S. at 64).

b. The terminology "may be viable" is clear and concise and capable of interpretation by the medical community.

Secondly, the Commonwealth avers that no practicable basis exists to define the physician's duty with any more

[10]Section 2(2) of the Missouri Act defined "viability" as "that stage of fetal development when the life of the unborn child ***may be*** continued indefinitely outside the womb by natural or artificial life-supportive systems" (428 U.S. at 84). (Emphasis added). Act of June 14, 1974, HCS House Bill 1211 §2(2), VAMS §188.015(3).

precision, and that such duty is no more onerous than that falling on other classes of fiduciaries or that which a physician encounters in any other area of medical practice.

The physician is required to follow two objective standards to avoid liability. First, prior to performing the abortion, he must make a determination that the fetus is viable or may be viable, based on his "experience, judgment or professional competence". Secondly, if such a determination is positive, he must attempt to preserve the life and health of the fetus through the exercise of "professional skill, care and diligence".

In the definitive article *The Void-For-Vagueness Doctrine in the Supreme Court*, 109 U. Pa. L. Rev. 67 (1960), Professor Freund was cited as having distinguished "three grades of certainty in the language of statutes of general operation: precisely measured terms, abstractions of common certainty, and terms involving an appeal to judgment or a question of degree". The "abstractions of common certainty" were those which had an "external object-referent" or a "pointing definition" and were "inherently capable of fixation", (109 U. Pa. L. Rev. at 90 citing Freund, *The Use of Indefinite Terms in Statutes*, 30 Yale L. J. 437 (1921).

It is submitted that the standards established in §5(a) are such "abstractions of common certainty". They do not rely on an ad hoc, erratic, subjective evaluation but instead incorporate and rely on firm, well-established professional medical judgment. As a result they notify physicians as to what conduct on their part is prohibited.

It is well established that any criminal act must be defined with appropriate definiteness. However, in the early case of *Connally v. General Construction Co.*, 269 U.S. 385 (1926), the Court noted that it is only necessary to set forth a firm standard of guilt so that men of common intelligence would not have to guess at its meaning.

> . . . [B]ut it will be enough for present purposes to say generally that the decisions of the court, upholding statutes as sufficiently certain, rested upon the conclusion that they employed words or phrases having a technical or other special meaning, well enough known to enable those within their reach to correctly apply them, *** or a well-settled common-law meaning, notwithstanding an element of degree in the definition as to which estimates might differ, *** or, as broadly stated by Mr. Chief Justice White in United States v. L. Cohen Grocery Co., 255 U.S. 81, 92, 41 S.Ct. 208, 301, (65 L.Ed. 516, 14 A.L.R. 1045), "That, for reasons found to result either from the text of the statutes involved or the subjects with which they dealt, a standard of some sort was afforded". (269 U.S. at 391-392).

The well recognized medical standards set forth in §5(a) are sufficiently definite under the rule stated by the Court in *Connally*. See also *Hynes v. Mayor and Council of Borough of Oradell*, 425 U.S. 610 (1976).

Similar medical standards in statutes allowing for criminal sanctions have previously been reviewed by this Court. Most recently in *Danforth*, your Honorable Court struck a similar criminal penalty only because the standard of care requirement upon which the penalty relied was over-inclusive. See note 6, *infra*.

In *Doe v. Bolton, supra*, a Georgia abortion statute was attacked as unconstitutionally vague in that criminal sanctions attached to the performance of an abortion except when it is "based upon (the physician's) best clinical judgment that an abortion is necessary" (410 U.S. at 200). It was alleged that the word "necessary" did not warn a physician of what conduct was proscribed, that the statute was wholly without objective standards and subject to diverse interpretations, and that doctors will choose to err on the side of caution and will be arbitrary (410 U.S. at 192).

The Court held that this determination of necessity was not so subjective and unpredictable as to void the statute.

The vagueness argument is set at rest by the decision in United States v. Vuitch, 402 U.S. 62, 71-72, 91 S. Ct. 1294, 1298-1299, 28 L.Ed.2d 601 (1971), where the issue was raised with respect to a District of Columbia statute making abortions criminal "unless the same were done as necessary for the preservation of the mother's life or health and under the direction of a competent licensed practitioner of medicine". That statute has been construed to bear upon psychological as well as physical well-being. This being so, the Court concluded that the term "health" presented no problem of vagueness. "Indeed, where a particular operation is necessary for a patient's physical or mental health is a *judgment that physicians are obviously called upon to make whenever surgery is considered*". *Id.*, at 72, 91 S.Ct. at 1299. This conclusion is equally applicable here.

Whether, in the words of the Georgia statute, "an abortion is necessary" *is a professional judgment that the Georgia physician will be called upon to make routinely*.

> We agree with the District Court, 319 F. Supp. at 1058, that the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. (410 U.S. at 191-192) (Emphasis added).

Similarly, §5(a) confines its scope to a medical setting where the rules of conduct are firmly established and where the standards are well known and where deviation from such standards can be determined without resort to conjecture.

Appellees additionally argued below that the absence of mathematical and semantic exactitude in §5(a) restrains them in the exercise of their medical practice and thereby interferes with the execution of their duties and their

patient's constitutional right to privacy.[11] The legal refutation of this argument is implicit in *Roe's* choice of viability as the threshold of compelling state interest. Despite patient request for and physician agreement to perform an abortion, the Supreme Court specifically stated that the state could forbid abortions at the point of viability except insofar as the life or health of the mother was concerned.

In addition, appellees' argument must be rejected in that to hold otherwise would deprive this section of any material effect. Such an interpretation would allow the physician to cavalierly, wrongfully and without fear of recourse, refuse to make a determination of viability in direct contradiction of the obvious intent of this section to exercise the state's compelling interest in protecting the life of a viable fetus. In the court below, appellee Gerstley, testifying on behalf of plaintiff Obstetrical Society, stated the Society's elitist view that *physicians and hospitals* should regulate abortion practice as opposed to the federal government or state legislatures! (19a)

III. THE JUDICIARY HAS NO POWER TO DELINEATE LEGISLATIVE PRIORITIES REGULATING POST-VIABILITY ABORTIONS

a. Constitutional Principles mandate judicial abstention in political questions of public policy.

In the lower court, appellees challenged the constitutionality of §5(a) on the additional basis that the legislature's ban on post-viability abortions is overly broad and violative of the woman's right of privacy and of the alleged right to genetic counseling to terminate the pregnancy of a defective fetus, and has an overall chilling effect on her constitutional rights as set forth in *Roe v. Wade*.

[11]See appellee Franklin's testimony excerpted in Argument I, *infra*, to the effect that he and his patient should *always* be the sole determinators of abortion practice and procedures.

The appellants submit that these arguments are wholly without merit. Nowhere in this Court's recent abortion decisions has your Honorable Court delineated any difference *whatsoever* in the state's compelling interest in viable fetal life based upon a diagnosed genetic defect or chromosomal disease.

Rather, this Court sanctioned the state's interest in *all* viable fetal life in opposition to the concept of abortion on demand:

> (c) For the stage subsequent to viability, *the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion* except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. *Roe v. Wade, supra,* 410 U.S. at 164-165. (Emphasis added).

The Court also stated:

> Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy. *The third reason is the State's interest — some phrase it in terms of duty — in protecting prenatal life.* 410 U.S. at 150. (Emphasis added).

The intention of the Court in *Roe* to reserve to state legislatures those areas of abortion regulation not subject to constitutional attack was made even clearer:

> Appellant and some amici argue that the woman's right is absolute and that she is entitled to terminate her pregnancy *at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.*
>
> We — conclude that the right to personal privacy includes the abortion decision, but that this right is *not unqualified* and must be considered against *important state interests in regulation.* 410 U.S. at 153-154. (Emphasis added).

Appellants respectfully assert that neither the statutory court nor your Honorable Court has the power to review the wisdom of a statute not penalizing the exercise of a fundamental right in an area of valid state interest, and that such is the case here. *Wyley v. Warden*, 372 F.2d 742 (4th Cir. 1967). Every favorably inference must be given the legislature in considering the constitutionality of an Act, with all doubts being resolved in their favor. *United States v. Vuitch*, 402 U.S. 62 (1971); *Munn v. Illinois*, 94 U.S. 113 (1876).

Appellees would have this Honorable Court mandate to the various States that, in regulating post-viability abortions, they must give weight to countervailing interests and considerations, including genetic counseling, diagnosis of forseeable birth defects, and other circumstances surrounding the conception and/or development of the child aside from the state's interest in protecting viable life. Appellees are asking this Court to indulge in blatant judicial legislation at variance with our basic constitutional framework as enumerated in the Ninth and Tenth Amendments. Appellees would have this Court transgress these enumerated powers and sit as a super-legislature, by specifying public policy considerations and guidelines for legislative action in the abortion field, thus thrusting the Court into political activity of the most fundamental sort.

In *Harrington v. State of Georgia*, 163 U.S. 299 (1896), the Supreme Court stated:

> The whole theory of our government, federal and state, is hostile to the idea that questions of legislative authority may depend . . . upon opinions of judges as to the wisdom or want of wisdom in the enactment of laws under powers clearly conferred upon the legislature. 163 U.S. at 304.

More recently, in *Younger v. Harris*, 401 U.S. 37 (1971), your Honorable Court reaffirmed the vitality of this concept:

> . . .[A] recognition of the fact that the entire country is made up of a Union of separate state governments, and a continuance of the belief that the National Government will fare best if the States and their institutions are left free to perform their separate functions in their separate ways. This, perhaps for lack of a better and clearer way to describe it, is referred to by many as "Our Federalism," . . . What the concept does represent is a system in which there is sensitivity to the legitimate interests of both State and National Governments, and in which the National Government, anxious though it may be to vindicate and protect federal rights and federal interests, always endeavors to do so in ways that will not unduly interfere with the legitimate activities of the States. It should never be forgotten that this slogan, "Our Federalism", born in the early struggling days of our Union of States, occupies a highly important place in our Nation's history and its future. 401 U.S. at 44-45.

Clearly, it is not for the judiciary to decide whether the legislature has chosen the best remedy to meet an evil. The courts decide only whether the means chosen are constitutional and related to the evil sought to be abolished. *Staten Island Loaders v. Waterfront Commission of New York Harbor*, 117 F. Supp. 308 (S.D. N.Y. 1953). In this instance, no one can reasonably dispute that the prohibition of Section 6(b) against abortions after viability unless the mother's life or health dictates otherwise, is a natural option reasonably related to the state's interest in protecting fetal life. So too is the mandate of §5(a) which sets forth utilization of a standard of care.

Unlike the birth control law in *Griswold v. Connecticut* 381 U.S. 479 (1965), the statute in this case pointedly legislates in an area of compelling state interest and does not invade the penumbra of a constitutionally protected right, *i.e.*, the privacy of the marriage relationship violated in *Griswold*. Questions regarding the quality of life versus consideration of the rights of viable fetuses, are questions of

public and not private morality once viability has attached. These questions inextricably involve the resolution of potentially competing societal interests of legally significant classes entitled to *legislative* concern. As Mr. Justice Douglas stated in the Opinion of the Court in *Griswold, supra,* "we do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch upon economic problems, business affairs, or social conditions". *Griswold v. Connecticut, supra,* 381 U.S. at 481.

An examination of this question from the other side of the coin, *i.e.*, the appropriateness of state action, aside from the inappropriateness of federal intervention, reveals that §5(a) is a valid exercise of the state's police power.

The "Police Power" of a state arises out of the reservation of powers contained in the Tenth Amendment. *State v. Whitaker,* 335 U.S. 525 (1949). It is a matter of legislative prerogative in which the legislature has wide discretionary powers; it includes that which is essential to public safety, health and morals. *Lamm v. Volpe,* 449 F.2d 1202 (10th Cir. 1971). The classic statement of the parameters of this power was enunciated in *Lawton v. Steele,* 152 U.S. 133 (1894):

> To justify the State in thus interposing its authority in behalf of the public, it must appear, first, that the interests of the public generally, as distinguished from a particular class, require such interference; and, second, that the means are reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals. 152 U.S. at 137.

This statement has been repeatedly cited and adopted in more recent cases. *Goldblatt v. Town of Hempstead,* 369 U.S. 590, 594-95 (1962); *Sweeney v. Murphy,* 39 App. Div.2d 306, 308, 334 N.Y. S. 2d 239, 241(1972); *Commonwealth v. Harmon Coal Co.,* 452 Pa. 77, 93, 306 A.2d 308, 317 (1973). Under these criteria, §5(a) is clearly a proper exercise of the state's police power.

The threshold question of state interest in the viable fetus, as an appropriate focus of public concern, was answered in *Roe v. Wade, supra.* The means selected to implement this concern is indeed the *only conceivable means* to effect the proper purpose of protecting prenatal life, *i.e.*, prohibiting abortifacient techniques that endanger viable life. There is simply no way the state can countenance, for example, a dilation and evacuation abortion of a viable fetus, absent medical necessity, if alternative medical procedures, in the best judgment of the physician, could result in a live birth. To permit otherwise would be to abandon totally the statutory purpose of protecting viable life, which this Honorable Court states may even be viewed as the state's *duty*! *Roe v. Wade, supra,* 410 U.S. at 150.

b. The viable fetus diagnosed prenatally as defective has a right to life protectible by the state.

With regard to congenital diseases and birth defects, appellees argue that the pain and suffering visited upon the parents and the child born with a progressively degenerative and fatal disease renders §5(a) of the Act oppressive by requiring the birth of a fetus so diagnosed at the latter stages of pregnancy. Appellees' approach would sanction (albeit out of compassion for the parents and presumably for the fetus[12]) state action effecting the termination of genetically "disfavored" life.

The Commonwealth asserts initially that testing for genetic defects or diseases is for the most part completed *prior* to the attainment of viability by the fetus.[13] If, however, the testing is not completed until after viability, the

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[12]To support their position, appellees must, however, argue that there are instances where death is preferable to life, notwithstanding the fact that the terminated, legally-recognized being has no choice in the decision and no culpability leading to the irreversible decision to abortion, a clear violation of the Fifth and Fourteenth Amendments.

[13]At trial appellees offered the testimony of Hope Punnett, a genetic counselor, for the alleged purpose of demonstrating that if an interpreta-

(Continued)

state's compelling interest in protecting that life is paramount.

Consequently, it is important to examine the procedure by which prenatal diseases or defects are diagnosed and the time frame within which testing is completed.

There are approximately 150,000 babies born each year in the United States with congenital malformation, half of which causes significant developmental disabilities. Mitchell S. Golbus, M.D., "Prenatal Diagnosis of Genetic Disorders", Contemp. OB/GYN Vol. 7 (Jan. 1976).

Some of the defects can be diagnosed prenatally through the use of a technique known as amniocentesis. Amniocentesis is a procedure by which a sample of the amniotic fluid surrounding the fetus is removed and tested. John S. O'Brien, M.D., "Tay-Sachs Disease: Prenatal Diagnosis", Contemp. OB/GYN. Vol. 3 (Dec. 3, 1976). The cells in the amniotic fluid are cultured and used for chromosome studies and examined for enzyme deficiencies and other evidence of genetic defects. Golbus, *supra*. The procedure has been used to determine the existence of certain fetal chromosome abnormalities (including Down's

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tion of §5(a) set viability at 20 weeks, some couples would be denied the "option" of genetic counseling. Appellants asked for an offer of proof and challenged the testimony as irrelevant. Appellants later moved to strike this testimony but the motion was denied.

However, there was no testimony presented which set viability at 20 weeks. There was extensive testimony that the viability of each individual baby must be determined on the circumstances peculiar to mother and child utilizing reasonable medical judgment. Testimony revealed that it is impossible to utilize gestational age alone in determining viability. Commonwealth witnesses, when pressed to do so, generally spoke of the 26-28 week viable baby.

Dr. Punnett's testimony revealed only one instance where the diagnostic tests were not completed in time for the woman to have an abortion prior to 20 weeks' gestation. That particular abortion was performed at 18-22 weeks' gestation.

Consequently, if the fetus who is the subject of genetic counseling is not viable, the Pennsylvania Act would not prohibit an abortion.

Syndrome); neural tube defects; metabolic disease (including Tay-Sachs); and X-linked diseases (at least to the extent it identifies the sex of the fetus). Nancy E. Simpson, Ph.D., *et al.*, "Prenatal Diagnosis of Genetic Disease in Canada: Report of a Collaborative Study", CMA Journal, 115:739 (Oct. 23 1976).

Amniocentesis is not performed without risk. Although it has been shown to be a generally safe, accurate and reliable procedure, it should be monitored by ultrasonography to better determine fetal and placental placement, performed by a trained obstetrician and carried out in a major health service center, Simpson, *supra*. The risks associated with transabdominal amniocentesis involve those to the mother (blood group sensitization, infection and intra-abdominal bleeding) and to the fetus (injury inflicted by the needle, abortion and possibility of an induced malformation, Golbus, *supra*.

Maternal complications, including spontaneous abortion, within 72 hours of amniocentesis occurred in 3.6% of the 1,223 amniocentesis studies in Canada between 1972 and 1975, Simpson, *supra*.

> It should be emphasized that the amniocentesis is a procedural endpoint and must be preceded by the careful recording of a family pedigree and appropriate genetics counseling, ... (emphasizing) not only the risk of having a genetically defective infant but also the dangers of amniocentesis. Golbus, *supra*.

Amniocentesis is also performed on so-called high-risk mothers, *i.e.*, those who are over 40 years of age, or have other children with genetic defects, (Simpson, *supra* and Golbus, *supra*), or who are members of a sub-group which is known to have a high percentage of carriers of genetic disease such as Tay-Sachs. O'Brien, *supra*.[14]

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[14]According to a study of over 27,000 pregnancies in Charleston, South Carolina, approximately 1.6% of pregnant women are over 40 years

(Continued)

In order to allow for sufficient development of fetal cells and the presence of an adequate quantity of amniotic fluid, the amniocentesis should not be performed until mid-trimester of pregnancy, preferably not before the fifteenth or sixteenth gestational week (Simpson, *supra).*[15]

Two or three weeks are required to grow enough cells for chromosomal studies, and two weeks more are required to grow enough cells for biochemical analysis (Simpson, *supra*). This time table would allow adequate time to perform an abortion with the intention of destroying the fetus before viability is reached.[16]

It is not appellants' purpose to denigrate the tragic situation which befalls the family of one born with severe mental and motor retardation or debilitating disease. The Commonwealth's position remains firm that the aims of the law must be to nurture that viable life and the family which

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old, and the incidence of Down's Syndrome in women of this age group is one in sixty. Edgar O. Harger III and Alexander R. Smythe II, "Pregnancy in Women over Forty", Obst. & Gyn. 49:257 (1977).

Overall there are approximately 5,000 Down's Syndrome babies born each year. Maya Pines, "Heredity Insurance", The New York Times Magazine, (4/30/78). The frequency of chromosome abnormality, including Down's Syndrome, in mothers over 40 has been estimated as high as one in twenty, with the risk increasing in women between 35-39 to one in sixty (Simpson, *supra*, and Golbus, *supra)*, and in women under 35 one in six hundred (Pines, *supra)*. It has been estimated that there is a one in one hundred chance that women over 35 who have had a child with chromosome abnormality will have another (Simpson, *supra)*. Finally, before genetic testing for Tay-Sachs disease began in the United States only 50 to 60 cases of this disease occurred annually (Pines, *supra*).

[15]Dr. Golbus states that it is now his practice to perform amniocentesis at 15 *menstrual* weeks (13 gestational weeks). (Golbus, *supra* at 119).

[16]In the Canadian study of 1,223 amniocentesis procedures, only one amniocentesis was needed for diagnosis in 84% of the pregnancies; of the 1,020 pregnancies studied, only 3.7% of the amniocentesis were inconclusive due to culture failure (Simpson, *supra*).

surrounds it so that it might reach its fullest potential in the complete enjoyment of its constitutional guarantees.[17]

In light of the almost daily advances being made through medical research not only in earlier diagnosis but in the treatment of supposedly untreatable and irreversible terminal diseases, appellants strongly urge this Court to refrain from mandating a justification for post-viability abortions entitled "Genetic Disease or Defect". Determination of which genetic defects are so serious or so incurable and tragic as to warrant the death of the viable fetus who through chance of nature happens to possess that defect is of such proportion as to defy the ability of judgment of mortals. At a conference sponsored by the Hastings Center and the National Institutes of Health, some 85 scientists, philosophers, lawyers and theologians met in October of 1971 to discuss ethical questions raised by genetic counseling. As Joan Lynn Arehart describes in Science News, 100:298-300 (Oct. 30, 1971):

> Yet, even if one decides when a fetus becomes human, there is the thorny question of what constitutes a genetically sound person. Every American carries at least 5 to 10 defective genes, according to Kayback, another alumnus of the Hastings conference. Lederberg admitted that being a Nobel laureate, as he is, assures even him no passport into the realm of normalcy. In fact, most panelists present uncomfortably agreed that had a treatment not been found for PKU babies several years ago, PKU victims might today be included on the defective fetus-abort list. Carried to its logical conclu-

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[17]Supportive government health and welfare services are available to families so situated in Pennsylvania, free of charge or at nominal cost, to ease the burden of such child-rearing. The federal food stamp program, certain social security benefits, and the aid to dependent children, and public assistance programs are but a few of the existing governmental resources, federal state and county.

If the family does not desire to keep the child, the adoption alternative is available, in addition to placement of the child in foster homes, and state-financed child care shelters.

> sion, some participants prophesized, there is reason to believe that all human "defectives", Rh negatives and left-handers alike, might eventually be defined out of the human chromosome lottery.

See also the numerous questions raised in Amitai Etzioni's "Amniocentesis: A Pandora's Box", Medical Opinion, p. 53 (Aug. 1976). Dr. Etzioni succinctly argues at p. 54:

> Will this turn society into a Nazi-like biologistic and racist camp that focuses on people's genetic qualities instead of their efforts and achievements?

It is interesting to note that both the Pennsylvania Governor's Abortion Law Committee of 1972 and the Pennsylvania Legislature heard testimony from organizations for the retarded and handicapped — none of whom testified in favor of abortion as the answer to their problems.

While there is not a person who does not sympathize with a retarded or handicapped child and that child's family because of the great burden they face — who is to say to that child that his quality of life does not meet the "community standard" because he is different.[18] The questions medically, morally and philosophically are endless, troubling and frightening in implication.

The legislature in this instance chose not to take the smallest step down the path of genetic or social selections formerly trod by the ancient Spartans, who history tells us laid the weakest new-born infants on the hillsides of Sparta to die, supposedly to insure the development of a healthy and superior warrior race. Appellants are not persuaded that

[18]An additional issue should be considered with respect to the severe psychological impact a sanctioning of abortion for viable "defective" life would have on handicapped members of society who might feel that society has placed a negative value on their right to life and that were they conceived presently or in the near future, they would not be permitted to live.

our constitutional traditions would permit such a development. However, it is even more certain that nothing in our constitutional system compels such a result. If this type of evolution is to transpire, it is a question of public policy to be made by the body politic and not the courts.

This Court has drawn the line in determining a person's right to life, by constitutional interpretation, at viability. The Commonwealth strongly urges your Honorable Court to stand firm with respect to viability by reaffirming in this regard the precedents of *Roe v. Wade*, *Doe v. Bolton* and *Planned Parenthood v. Danforth*.

CONCLUSION

It is respectfully requested that your Honorable Court reverse the judgment below and reinstate §5(a) of the Abortion Control Act in full force and effect.

In lieu thereof, appellants request that the terminology "or may be viable" be severed and that the remainder of §5(a) be reinstated in full force and effect.

Respectfully submitted,

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